

PARISH (W.H.)

Reopening of the abdomen

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REOPENING OF THE ABDOMEN DURING THE FEW DAYS FOLLOWING A CÆLIOTOMY.*

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In a large number of cœliotomies the following four cases are the only ones in which I have reopened the abdomen shortly after the first operation. Doubtless some cases would be saved by this procedure in the practice of every busy operator :

Mrs. G., after supposing herself pregnant for two months, was seized with the usual symptoms of ruptured tubal pregnancy. For several weeks she was under the care of various physicians. A tumor of the size of an adult head developed in the right half of the lower abdomen and pelvis. General peritonitis supervened, with extreme exhaustion and emaciation.

I now saw the patient for the first time, and at once made an incision directly into the tumor above Poupart's ligament, and evacuated about three pints of grumous blood intermixed with pus. This incision did not open into the peritonæum. Marked improvement occurred until the third day, when vomiting returned, which soon became stercoraceous. Various attempts to secure movements of the bowels failed, and death seemed imminent. The emaciation was so great that the coils of intestines and their vermicular action could be seen clearly through the abdominal walls. The distention was great except in the region of the descending colon.

I now made an incision in the left linea semilunaris on a level with the umbilicus. Everywhere the intestines were matted together by dense adhesions, and evidently the contraction of the wall of exudate about the blood-and-pus mass had dragged upon the adherent bowels to such an extent as to produce strangulation, which would have proved fatal unless relieved. I tore and cut all adhesions within reach and closed the incision last made without drainage.

The incision into the tumor was kept open for a number of days. The patient recovered, and she has since been delivered safely at the full period.

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In this case, if a median incision had been also made on the day of the first operation and adhesions had then been broken up, the dangers of strangulation of the bowel would have been avoided. This was not done at that time because of the extreme exhaustion of the patient.

For several months Mrs. N., a resident of New Jersey, had been suffering with hæmorrhage and pressure symptoms because of a fibroid tumor of the uterus reaching to the umbilicus. I did a supravaginal hysterectomy in one of the private rooms of St. Agnes' Hospital. It was necessary to tear up vascular adhesions. The operation was done largely in the Trendelenburg position. The bleeding seemed controlled by ligature, but a drainage-tube was nevertheless introduced. On my return to the patient, twelve hours afterward, the dressing was soaked with blood and the tube was occluded with a soft clot. On withdrawing this, blood ran from the tube. The patient was a strong, vigorous countrywoman, and the pulse (88) showed no ill effects from the loss of blood. However, as the blood continued to run from the tube, I again had the patient etherized and opened the abdomen at midnight. In the Trendelenburg position, after removing about six ounces of blood from the pelvis, I easily found the bleeding point and applied effectively a ligature.

In this instance the elevation of the pelvis during the operation may have prevented oozing, which made its appearance after the patient had been placed in a horizontal position. The reopening of the abdomen was indicated, and convalescence progressed favorably, except that the lower angle of the wound did not close by first intention.

In the spring of 1895 I removed one moderately enlarged ovary—a small cystoma—a very simple operation.

After recovering from the ether the pulse ran up to 130, with evidence of more than usual abdominal pain. The patient was an intellectual young lady of wealthy parentage.

On the morning after the operation it suddenly occurred to my mind that I had left a small gauze sponge within the abdomen immediately under the incision. I saw at once my first assistant, and he likewise felt convinced that the gauze was in the abdomen. Twenty hours after the operation, with the pulse still 130, I reopened the abdomen and made a thorough examination of it but did not find any gauze. Everything was in perfect condition. The abdomen was reclosed, gradually the pulse became reduced in frequency and recovery promptly followed.

This patient is now entirely well, and I am confident there is no gauze in the abdominal cavity, though my assistant is still, I think, of the opinion that it was not removed.

Mrs. B., operated on in a private ward of St. Agnes' Hospital.

Both sets of appendages were removed because of double pyosalpinx. Numerous dense adhesions were broken up. Douching with boiled water was resorted to, and a glass drainage-tube placed in for twenty-four hours. The subsequent symptoms for several days were rather favorable than otherwise, except that the temperature kept about 100° and the pulse about 100 per minute. On the sixth day I left the city, and on my return on the eighth day the resident physician informed me at night that the patient would probably not live until morning. On visiting her, I found her indeed exceedingly ill: temperature 103.5° , pulse 130, vomiting frequent, abdomen much distended and tender, features pinched. General peritonitis was evidently present and death was imminent. I at once had the patient etherized and taken to the operating room. I opened the previous incision and found, as far as the eye or the finger could examine, universal and somewhat firm adhesions, involving not only the pelvic but also the abdominal peritonæum. I broke up the adhesions everywhere and found no fluid of any character, no flocculi, and none of the appearance of the usual form of septic peritonitis. After douching, drainage was again resorted to. In twelve hours the patient expressed herself much improved. Vomiting had ceased, the features had lost the anxious and pinched appearance, the pulse and temperature were better, convalescence had already begun. Complete recovery followed.



